DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED 9/21/07

PRINTED: 09/04/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G145	A. BUILDING _____ B. WING _____	R 08/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This follow up survey was conducted August 27 and 28, 2007. The client sampling included three clients selected from the initial survey conducted on July 13, 2007 and two other clients who was not in the previous sample. As a result of issues derived from staff interviews, and record review during the follow up survey, it was determined that although some improvements were identified, the facility has continued to not meet compliance at the Condition Levels of Participation in Governing Body, Facility Staffing, and Active Treatment. The findings of this follow up survey were derived from staff interviews at the group home and record reviews to include medical, administrative, clinical, and incidents reports. Two investigative reports involving an allegation of abuse on 7/23/07 and an allegation of theft on 7/15/07 was also reviewed.	{W 000}		
{W 100}	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.	{W 100}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 9.21.07

* deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 100}	Continued From page 1 This STANDARD is not met as evidenced by: Based on interviews and record review, the facility's governing body and management failed to implement controls to ensure a more rigorous monitoring of th provisions of continuous learning opportunities according to the facility's Plan of Correction (POC) dated 8/20/07. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at 5:40 PM, it was acknowledged that the case reviews scheduled for the first and third Tuesday of each month, record reviews, and monthly analysis of active treatment had not been implemented. The QMRP further revealed that she conducted the case review with Licensed Practical Nurse (LPN) and House Supervisor. When asked to see documentation of the review, the QMRP acknowledged that there was date or sign in sheet present in the record. Also see Federal Deficiency Report Citations W249 and W196	{W 100}	The governing body and management of MarJul Homes has implemented more controls to ensure a more rigorous monitoring of the provision of continuous learning opportunities as follows: 1) Case Review—1st & 3RD Tuesday of each month 2) QA Consultant a) record review b) monthly analysis of active treatment See attachment #1 The governing body will provide, monitor, and revise, as necessary, policies and operating directions which will ensure the necessary staffing, training resources, equipment and environment to provide individuals with active treatment and to provide for their health and safety. This will be accomplished by: 1) Revising the program director job description. See attachment # 2 2) Following the recommendations and working cooperatively with the internal quality assurance consultant. See attachment # 2	9-26-07
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by:	{W 102}		9-26-07

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{W 102}	Continued From page 2 The facility's governing body failed to maintain general operating direction over the facility to ensure the provision of active treatment and facility staffing [See W104]. The systemic effect of these practices during the follow-up visited continues to result in the failure of the governing body to adequately manage and govern the facility and to ensure active treatment needs and services are delivered. [See W158 and W195]	{W 102}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, staff interviews, and record reviews the governing body failed to ensure that the facility exercised general policy, budget, and operating direction over the facility. The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 5:58 PM, it was acknowledged that the facility have not contacted Clients #1, #2, #3, and #4's advocate, legal guardian, and/or family members to obtain consents forms or inform them about the use and side effects of psychotropic medications in which they were currently prescribed. Review of the Individual Support Plan (ISP) records on 8/27/07 at approximately 5:50 PM revealed no consents forms had been obtained for Clients 1 through 4. There was no documented evidence that the	{W 104}	1. The governing body, with the Program Director in conjunction with the Quality Assurance Consultant will ensure that all the individuals parents/guardians/advocates are informed of all medications and their side effects, and that they have given consents for all treatments. See attachment #3	9/26/07

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{W 104}	Continued From page 3 parents/guardians/advocates had been informed all medications and their side effects, and they have given consent for all treatments as indicated in the Plan of Correction dated 8/20/07. 2. The governing body failed to ensure that the clients #1, #2, and #3 received active treatment in a consistent and persistent manner as described in W249 and W196. 3. The governing body failed to ensure that the policies were implemented to ensure the protection of clients rights. [See W264]	{W 104}	2. See W196 3. See W264	
{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a system had been developed to assist clients through legally sanctioned advocacy to ensure the protection of their rights due to their behavioral status, risk of treatment, and desire to refuse treatment for four of five clients in the sample. The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 5:58 PM, it was acknowledged that	{W 124}		

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{W 124}	Continued From page 4 the facility have not contacted Clients #1, #2, #3, and #4's advocate, legal guardian, and/or family members to obtain consents forms or inform them about the use and side effects of psychotropic medications in which they were currently prescribed. Review of the Individual Support Plan (ISP) records on 8/27/07 at approximately 5:50 PM revealed no consents forms had been obtained for Clients 1 through 4. There was no documented evidence that the parents/guardians/advocates had been informed all medications and their side effects, and they have given consent for all treatments according to the facility's POC dated 8/20/07. 2. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 5:58 PM, it was acknowledged that the facility have not contacted Clients #1, #2, #3, and #4's advocate, legal guardian, and/or family members to obtain consents forms or inform them about the use and side effects of psychotropic medications in which they are currently prescribed. Review of the Individual Support Plan (ISP) records on 8/27/07 at approximately 5:50 PM revealed no consents forms had been obtained for Clients 1 through 4. There was no documented evidence that the parents/guardians/advocates had been informed all medications and their side effects, and they have given consent for all treatments according to the facility's POC dated 8/20/07. Additionally, there was no evidence that the facility's Registered Nurse (RN) made follow up phones calls to the advocate, legal guardian, and/or family members to ensure all their questions and concerns have been thoroughly answered as indicated in the Plan of Corrections dated 8/20/07.	{W 124}	1. See W104 #1 2. The governing body, with the Program Director in conjunction with the Quality Assurance Consultant will ensure that all the individuals parents/guardians/advocates are informed of all medications and their side effects, and that they have given consents for all treatments. Additionally the RN will make a follow up call to the parents/guardians/advocates to ensure that all their questions and concerns have been thoroughly answered.	9-26-07

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{W 148}	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's QMRP failed to ensure that the individuals parents/guardians/advocates were notified of medications, consents, injuries, or treatment and this procedure will be monitored by the Program Director and the Quality Assurance Consultant according to the facility's POC dated 8/20/07 for four of five clients included in the sample. (Clients #1, #2, #3, and #4) The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 6:18 PM, it was acknowledged that the facility have not contacted Client #1, #2, #3, and #4 parent/guardian/advocates to notify them about medications, consents, injuries or treatments. There was no evidence throughout Clients 1 through 4 records to indicate that the parents/guardians/advocates had been informed of medications, consents, injuries, or treatments. 2. Record verification and interview with the QMRP acknowlegded that the facility's Registered Nurse (RN) had not made follow up phones calls to the advocate, legal guardian, and/or family members to ensure all their questions and concerns have been thoroughly answered as	{W 148}	1. The QMRP will ensure that the individual's parents/guardians/advocates are notified of medications, consents, injuries or treatments and this procedure will be monitored by the Program Director and the Quality Assurance Consultant. See Attachment #4 2. Following all signing of consent forms by the individual's parents/guardians/advocates the facility RN will make a follow-up call to ensure that all their questions and concerns have been thoroughly answered.	9.26.07 9.26.07

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{W 148}	Continued From page 6 indicated in the Plan of Corrections dated 8/20/07.	{W 148}		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator or designated representative or other officials in accordance with state law with in five working days of the incident, for one of five clients included in the sample.(Clients #1) The finding includes: Review of an investigation reports dated 8/1/07 on 8/27/07 at approximately 3:30 PM revealed an incident dated 7/23/07. According to the incident report, Client #1 arrived at his day program an informed staff that staff from from the group home pulled his left arm, sat on him, pushed him down, and pushed him down the step. The investigative report was initiated on 7/23/07 and signed off on by the Assistant Program Director on 8/1/07. The investigation was not forwarded to the Department of Health (DOH) until 8/20/07 (19 days later). Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 5:15 PM, it was acknowledged that the investigation was not done within five working days.	W 156	The QMRP will ensure that the facilities Incident Management Coordinator completes and submits all investigations within five working days and submits them to the Department of Health.	9/26/07
{W 158}	483.430 FACILITY STAFFING	{W 158}		

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{W 158}	Continued From page 7 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) [See W159]; and failed to ensure staff were adequately trained on appropriately implementing iactive treatment program and behavior interventions [See W189 and W191]. The systemic effect of these practices during the follow-up visited continues to result in the facility's failure to provide adequate staffing to ensure active treatment supports. ********** ********** Based on observations, staff interviews, and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) [See W159]; and failed to ensure staff were adequately trained on appropriately implementing iactive treatment program and behavior interventions [See W189 and W191]. The effects of these systemic practices results in the facility's failure to provide adequate staffing to ensure active treatment supports.	{W 158}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	{W 159}		

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{W 159}	Continued From page 8 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interviews, staff, and the Qualified Mental Retardation Professional (QMRP), the QMRP failed to ensure that client's active treatment program to include interventions were established, integrated, coordinated and monitored; failed to ensure the protection of clients' rights for for two of five clients included in the sample. The findings include: 1. The QMRP failed to ensure that clients received continuous active treatment services. [Refer to W196, W249] 2. The QMRP failed to ensure that clients' objective criterions, that had not been attained, had been considered for revision to increase the success for the clients.[Refer to W257]	{W 159}	1. See W196 & W249 2. See W257	
{W 189}	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and	{W 189}		

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{W 189}	Continued From page 9 competently. The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 6:25 PM, it was acknowledged all staffs had not been trained on implementing the Client #1's Behavior Support Plans (BSP). Review of the staff in service/orientation records on 8/28/07 at approximately 12:40 PM revealed six out of fourteen facility staff had been in service on Client #1's BSP. There was no documented evidence that the QMRP had trained all staffs on correctly implementing Client #1's BSP as indicated in the Plan of Correction (POC) dated 8/20/07. Note: It should be noted that one of four new staff working the second shift (4 PM to 12 PM) on 8/20/07 had received training on the Client #1's BSP. 2. Review of an investigative report dated 7/25/07 on 8/27/07 at approximately 3:55 PM revealed a recommendation that included all homes direct support staff professionals should be in-serviced on how to correctly handle all individuals funds. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:00 PM revealed that the facility had put a new system in place to track the clients money. The QMRP indicated that when Client #3 makes a purchase from the store, the following steps will occur: a. Staff will request a copy of the the receipt made from the purchase from the store b. Staff will monitor the client's change to ensure that he's getting the correct amount back made	{W 189}	1. The Psychologist has trained the QMRP to train and ensure that staff are correctly implementing the individuals BSP. The QMRP will also retrain review with the BSP to further ensure that it is being implemented correctly. Additionally, the psychologist will train all staff twice per year on all BSP's. See attachment #5	9.26.07

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{W 189}	Continued From page 10 from the purchase c. Staff will turn the receipt into the Home Supervisor d. The home supervisor will forward the receipt to the Administrator e. The administrator will file all receipts into the clients records. At approximately 7:07 PM on 8/20/07, Client #3 returned back from the local corner store. According to the direct care staff, Client #3 purchased a cup of coffee, chips and a soda with his three one dollar bills. Staff indicated that he did not monitor client to see how much his items cost or how much change he had gotten back. The staff further indicated that he did not ask for a receipt. There was no evidence that staff followed the facility's system on tracking the clients funds was effective. 3. Observations conducted on 8/27/07 from 3:30 PM to 8:30 PM revealed that Client #2's communication device was not used. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 7:15 PM acknowledged that staff had not been using Client #2's communication device in accordance with the Individual Support Plan (ISP) at the time of the survey. The QMRP indicated that she was unaware of how to use the communication device. The QMRP further indicated that she and the direct care staffs had not received training on the used of the communication device. Record verification on 8/27/07 at approximately 7:22 PM revealed an objective that read "will use his communications device to name two different items at any given time with total guidance. Further review of the staff in service/orientation record revealed no	{W 189}	The facility will implement the following system. 1. The staff will be inserviced on handling individual funds quarterly. 2. The staff will request duplicate receipts for **ALL** individual's purchases and rendered services (haircuts, etc.). 3. Staff will turn in the receipt to the House Supervisor. 4. The House Supervisor will copy the receipt and put the copy in the individual's financial book and the original will be sent to the MarJul Homes Business Office for filing in the duplicate individual's financial book. See Attachment #1 3. The QMRP has scheduled an in service in which a representative from Assistive technologies will be train staff on how to correctly operate the individuals communication device. See Attachment #6	9.26.07 9.26.07

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{W 189}	Continued From page 11 evidence that all facility staffs including the QMRP had been trained by the speech and language pathologists. There was no documented evidence that the objective was being implemented as recommended.	{W 189}		
{W 191}	483.430(e)(2) STAFF TRAINING PROGRAM View in-service training as a dynamic growth process. It is predicated on the view that all levels of staff can share competencies which enable the individual to benefit from the consistent, wide-spread application of the interventions required by the individual's particular needs. In the final analysis, the adequacy of the in-service training program is measured in the demonstrated competencies of all levels of staff relevant to the individual's unique needs as well as in terms of the "affective" characteristics of the caregivers and the personal quality of their relationships with the individuals. Observe the staff's knowledge by observing the outcomes of good transdisciplinary staff development (i.e., in the principles of active treatment) in such recommended competencies as: · Respect, dignity, and positive regard for individuals (e.g., how staff refers to individuals, refer to W150); Use of behavioral principles in training interactions between staff and individuals; · Use of developmental programming principles and techniques, e.g., functional training techniques, task analysis, and effective data keeping procedures;	{W 191}		

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MARJUL HOMES	4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 191}	Continued From page 12 · Use of accurate procedures regarding abuse detection and prevention, restraints, medications, individual safety, emergencies, etc.; · Use of adaptive mobility and augmentative communication devices and systems to help individuals achieve independence in basic self-help skills; and · Use of positive behavior intervention programming. §483.430(e)(2) Probes Does the staff training program reflect the basic needs of the individuals served within the program? Does observation of staff interactions with individuals reveal that staff know how to alter their own behaviors to match needs and learning style of individuals served? For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to effectively trained direct care staff on client #1's behavior strategies. The findings include: 1. The facility failed to ensure that all staff including new staff had been trained on Client #1's Behavior Support Plan (BSP). [See W189]	{W 191}	1. See W189	

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{W 191}	Continued From page 13 2. Review of an investigation Report dated 8/1/07 on 8/27/07 at approximately 3:30 PM revealed a recommendation that all direct staff personnel should be in serviced on Client #1's BSP with a focus on the proactive strategies as outlined by the psychologists. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 5:22 PM, it was acknowledged that only six of fifteen staff had been trained on Client #1's BSP since the incident occurred on 7/23/07. Further interview with the QMRP revealed that only one of four staff working the second shift on 8/20/07 had received training on Client #1's BSP. Review of the in service/orientation record on 8/28/07 at approximately 12:50 PM revealed an in service training dated 8/15/07. The training indicated that six of fourteen staffs had been trained on Client #1's BSP. Additional record review and interview with the QMRP revealed there was no other class scheduled for the other staff to received training on Client #1's BSP at the time of the survey.	{W 191}	2. See W189	
{W 195}	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide clients' with continuous active treatment [Refer to W196 and 249]; failed to revise programs/objectives as needed [Refer to W257]; and failed to ensure that the policies of the facility were implemented to ensure the protection of clients rights [Refer to W264].	{W 195}		

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{W 195}	Continued From page 14 The cumulative effect of these systemic practices results in the failure of the facility to deliver statutorily mandated active treatment to its clients.	{W 195}	See W196, W249, W257, W264	
{W 196}	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's management failed to implement monthly staff meetings to ensure continuous staff training of all Individual Program Plans (IPP). Additionally, the QMPP failed to conduct weekly record reviews of all IPP's and write a corresponding weekly note to ensure proper analysis of the individuals progress according to the facility's POC dated 8/20/07 for five of five clients included in the sample. (Clients #1, #2, #3, and #4) The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 6:30 PM acknowledged that the weekly record	{W 196}		

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{W 196}	Continued From page 15 reviews and notes had not been done to ensure proper analysis of Clients #1, #2, #3, and #4 progress. Further interview with the QMRP revealed that the home supervisor will perform daily review to ensure data is being documented. Record verification revealed no documented evidence or system in place of how the reviews were being conducted by the home supervisor. There was no documented evidence that a monthly scheduled had been implemented to ensure continuous staff training of all IPP's. Additionally, there was no documented evidence that the QMRP conducted weekly records, wrote corresponding weekly notes to ensure proper analysis of the clients progress, and that they home supervisor performed daily reviews to ensure data was being documented. 2a. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at 6:32 PM acknowledged that she had not conducted any monthly in service for all staff to teach them basic sign language and to encourage interaction between individuals and enhance their communication skills. Review of the staff in service/orientation records on 8/28/07 revealed no evidence that any of the facility staff had received training on basic language. There was no documented evidence that the home supervisor conducted monthly in service for staff to teach basic sign language as indicated in to POC dated 8/20/07. b. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at 6:37 PM acknowledged acknowledged that she had not made any visits to the clients day programs as indicated in the plan of correction dated 8/20/07.	{W 196}	1. The QMRP will conduct a visual record review and initial weekly, and incorporate the findings and outcomes in the routine QMRP note. 2a. The Home supervisor will conduct a monthly in service for all staff to teach them basic sign language and to encourage interaction between individuals and enhance their communication skills. See attachment # 7 2b. The QMRP will perform regular day program observations at least once monthly to encourage communication between the individuals' day program and their residence. See attachment # 8	9.26.07 9.26.07

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{W 196}	Continued From page 16 3. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 6:30 PM acknowledged that the weekly record reviews and notes had not been done to ensure proper analysis of Clients #1, #2, #3, and #4 progress. Further interview with the QMRP revealed that the home supervisor will perform daily review to ensure data is being documented. Record verification revealed no documented evidence or system in place of how the reviews were being conducted by the home supervisor. There was no documented evidence that a monthly scheduled had been implemented to ensure continuous staff training of all IPP's. Additionally, there was no documented evidence that the QMRP conducted weekly records, wrote corresponding weekly notes to ensure proper analysis of the clients progress, and that they home supervisor performed daily reviews to ensure data was being documented. ********** Based on observation, staff interviews and record review, the facility failed to ensure that clients #1 and #2 were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs). The findings include: 1. Client #1's IPP was reviewed on July 13, 2007 at approximately 7:25 PM. The documentation of program data was also reviewed. It was revealed through this review that client #1 had a program to use public transportation once bi-weekly independently upon request. The documentation reflected that client #1 used the public	{W 196}	The QMRP will conduct a visual record review and initial weekly, and incorporate the findings and outcomes in the routine QMRP note.	

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{W 196}	Continued From page 17 transportation on January 6, 2007, March 31, 2007, and September 30, 2006. There was no data for April, June, and July 2007. For May 2007, the data reflected that client #1 had engaged in the objective once for the month. 2. The facility failed to provide consistent opportunities to use recommended methods of communications. a. Client #2 was observed not using verbal communications, signs, or any communicative devices during the survey on July 12, 13, and 16 2007. Client #2's speech assessment dated two years ago (January 26, 2005) was conducted by the Speech Pathologist at the client's day program. This professional identified that client #2 had the following strengths: "following situational and commonly used social commands, making some needs known through the production of a few American sign language signs, and identifying and labelling a few pictures." The recommendations included: increase skills in sign language, labeling items, and following directions. It was also recommended that speech services in the residential setting be similar to the services provided at the day program. At the day program, clients participated in a daily sign language class and instructors were observed using "simple" signs (eat, drink, toilet, slow down,) to communicate. According to the day program instructor and the provided documentation, client #2 achieved signing bathroom , sit, wash/dry hands at the criterion of verbal/gestural prompting. No signing was implemented at the facility. Staff interviewed on July 13, 2007 at 6:15 PM stated that the facility had a book of signs and that client #1 helps the	{W 196}	1. The facility has implemented a schedule to ensure that each individual's travel training is completed on a regular basis. See attachment #9 2a. The QMRP will coordinate with the day program to ensure that the individuals communication device is being used effectively at the facility. See attachment # 10	9.26.07 9.26.07

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{W 196}	Continued From page 18 staff with signing. Staff interview on July 12, 2007 at 11:40 AM revealed that client #2 knows some signs and that staff can request client #1 to assist them. The staff stated that client #2 had a picture book of items and a communication device. Neither the picture book nor the communication device were observed being used by the client during the survey. b. A staff, who was interview on July 13, 2007 at 6:15 PM, indicated that client #2 "was totally unresponsive to the communicative device. The Coordinator interviewed on July 16, 2007 at 5:45 PM stated that a visit would be made to the day program because the client did not participate with the device while at the facility. The documentation at the facility reflected 98% disengagement with the device. Client #2's IPP did include an objective for the client to use his communicative device to name two different items at any given time with total guidance. The day program staff who was interviewed on July 13, 2007 at 10:00 AM indicated that client #2 was "doing well with his low tech language device for identifying items." It was stated that the client performs at 100% for locating and identifying beverages. It was further stated that when the client stands and the instructor signs bathroom he goes. Reportedly, client #2 utilized some signs with verbal prompts. It could not be determined that client #2's speech and language needs were being addressed in a manner that would allow him the full benefit of similar communicative efforts between the two programs.	{W 196}		

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{W 196}	Continued From page 19 There was no evidence that client #2 was encouraged to engage with the communicative device as it was not made available to him at the facility during the survey on three days. The device had been out for repairs and arrive back to the facility until July 12, 2007 at approximately 2:00 PM. 3. According to Client #3's individual program plan dated March 29, 2007, the client had an objective that read "will travel to and from his pre-vocational site each Friday using public transportation with verbal prompts. The documentation reviewed on July 13, 2007 at 5:45 PM from March 2007 to July 2007, with the exception of one trial in May 2007, the staff did not provide the client the opportunity to participate in her travel training program.	{W 196}	3. The facility has implemented a schedule to ensure that each individual's travel training is completed on a regular basis. See attachment #9	9.26.07
{W 209}	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's QMRP failed to ensure that the individuals parents/guardians/advocates were notified of medications, consents, injuries, or treatments; failed to address letters to each individual's circle of supports to inform them of individuals ISP and quarterly meetings, and all psychotropic medications reviews; the Program Director and the QA Consultant failed to ensure that these letters have been sent out according to the Plan of Correction (POC) dated 8/20/07 for of	{W 209}		

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{W 209}	Continued From page 20 five of five clients included in the sample. (Clients #1, #2, #3, and #4) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 6:18 PM acknowledged that the facility have not contacted Client #1, #2, #3, #4, and #5's parents/guardians/advocates to inform them about medications, consents, injuries or treatments. Further interview with the QMRP revealed that the letters to each individuals's circle of supports to inform them of individuals Individual Support Plans (ISP), quarterly meetings, and all psychotropic medications had not been written or mailed out. Record reviews conducted on 8/28/07 at approximately 12:23 PM revealed no letters had been written or mailed out in the correspondence section. There was no documented evidence that the Program Director and the Quality Assurance Consult ensured that these letters were written and sent out as indicated in the POC dated 8/20/07.	{W 209}	The QMRP will ensure that all parents/guardians/advocates are informed of medications, consents, injuries, and treatments. The QMRP will address a letter to each individual's circle of support to inform them of the individuals ISP and quarterly meetings, and all psychotropic medication reviews. The Program Director and the QA Consultant will oversee this operation to ensure that these letters have been sent. See attachment # 11 and Attachment #4	9/26/07
{W 214}	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview, and review of medical records, the facility failed to ensure that comprehensive functional assessments were conducted for five of five clients in the sample. The findings include:	{W 214}		

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{W 214}	Continued From page 21 Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 6:50 PM revealed that she has no knowledge of a money management assessment for Client #1 or even know how to complete one. Further interview with the QMRP acknowledged that none of the clients have a money management assessment. Record review conducted on 8/28/07 at approximately 12:30 PM revealed that Clients #1, #2, #3, #4, and #5 did not have a money assessment located in the records.	{W 214}	Money management assessments have been completed for all individuals. The assessments will be filed in each individuals ISP book. Also, the forms will be updated on the date of the persons ISP meeting. See Attachment #12	9.26.07
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs) for two of five clients included in the sample. (Client #2 and #3) The findings include: 1. The facility failed to ensure continuous active treatment by not revising programs after clients failed to progress. [Refer to W257] 2. Interview with the Qualified Mental Retardation	{W 249}	1. The QMRP revised individual #3 objective at the end of July. The purpose of this revision was to increase the level of assistant that the individual needed inorder to be successful at achieving the goal. The revised goal read that he will write his home address with the help of a cue card with touch prompts as needed twice a week for three consecutive months See July and August data collection sheets.	9.26.07

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{W 249}	Continued From page 22 Professional (QMRP) on 8/27/07 at approximately 7:15 PM acknowledged that staff had not been using Client #2's communication device in accordance with the Individual Support Plan (ISP) at the time of the survey. The QMRP indicated that she was unaware of how to use the communication device. The QMRP further indicated that she and the direct care staffs had not received training on the used of the communication device. Record verification on 8/27/07 at approximately 7:02 PM revealed an objective that read "will use his communications device to name two different items at any given time with total guidance. Further review of the staff in service/orientation record revealed no evidence that all facility staffs including the QMRP had been trained by the speech and language pathologists. There was no documented evidence that the objective was being implemented as recommended.	{W 249}	2. The Staff have been trained how to correctly operate the communication device. And QMRP will ensure the objective is being implemented as written.	9.26.07
{W 257}	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on interview with the direct care staff at the facility and review of client's individual program plan (IPP),documentation of progress, and review of the Qualified Mental Retardation Professional (QMRP) notes, the facility failed to ensure that objective criterions that had not been attained by clients [#3] had been considered for revision to	{W 257}		

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{W 257}	Continued From page 23 increase the success for the clients. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:07 PM, it was acknowledged that Client #3's objective to "write his home address with the help of a cue card with one verbal prompts twice a week for 3 consecutive months" had not been revised.	{W 257}	See W 249 #1	
{W 264}	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on interview and record review, the Human Rights Committee (HRC) failed to ensure that the person signing the medication/BSP consent was aware of the individual's condition, medication, side effects, and rights for four of five clients included in the sample. (Clients #1, #2, #3, and #4) The findings include: Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:15 PM, it was acknowledged that the facility's	{W 264}		

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{W 264}	Continued From page 24 HRC had not reviewed/discussed the person signing the medication/BSP consents for Clients #1, #2, #3 and #4 was aware of the individual's condition, medication, side effects and rights. Review of the clients records on 8/27/07 and 8/28/07 revealed no documented evidenced that the facility's HRC had reviewed and discussed the person signing the medication/BSP consents was aware of the individual's condition, medication, side effects and rights as indicated in the Plan of Correction dated 8/20/07.	{W 264}	The human rights committee will review and approve the consent forms to ensure that the person signing the medication/ BSP consent is aware of the individual's condition, medication, side effects and rights. See Attachment # 13	9.2007
{W 289}	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on interview and record review, the psychologist failed to revise the Behavior Support Plans (BSP) to incorporate all psychotropic medications according to the facility's Plan of Correction (POC) dated 8/20/07 for five of five clients included in the sample. (Clients #1, #2, #3, #4, and #5). The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:18 PM, it was acknowledged that the psychologist had not revised the Behavior Support Plan to include all psychotropic medications for Clients #1, #2, #3, #4, and #5.	{W 289}		

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{W 289}	Continued From page 25 Review of the BSPs for these Clients on 8/28/07 at approximately 12:45 PM revealed that their medications were no included as part the plans. There was no documented evidence that the psychologist revised the BSPs to incorporate all psychotropic medication.	{W 289}	2. The psychologist will revise the BSP to incorporate the use of psychotropic medications. The BSP will be reviewed and approved by the HRC and incorporated into the ISP which is approved by the individuals IDT. See Attachment #3	9/26/07
{W 316}	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure that the topic of an attempt at decreasing the psychotropic medications was discussed with the psychologists and the psychiatrist according to the POC dated 8/20/07 for one of five clients included in the sample. (Client #2) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:25 PM acknowledged that the meeting between the psychologist and psychiatrist to discuss decreasing Client #2's psychotropic medications did not occur on 8/23/07 as indicated in the POC dated 8/20/07. The QMRP indicated that the psychotropic medication meeting was cancelled by the psychiatrist and rescheduled for 8/30/07. ********** ********** Based on review of psychotropic medication review documents and physician orders, and staff	{W 316}		

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{W 316}	Continued From page 26 interviews the facility failed to attempt to decrease the psychotropic medications for one of three clients (#2) in the sample. The finding includes: During the medication administration that was observed on July 12, 2007 at 7:10 PM, client #2 was administered Clonazepam 0.5 mg and Risperdal 2 mg. The LPN, interviewed on July 12, 2007 at 11:40 AM, indicated that client #2 had not presented any behavioral episodes and she could not recall the last episode. Another staff, interviewed on July 13, 2007 at 6:15 PM, indicated that client #2 "has not had too many episodes, very infrequent". The day program staff, interviewed on July 13, 2007 at 10:00 AM, stated he/she could not recall the client displaying his targeted behavior. The behavioral documentation from August 2006 to June 2007, reviewed on July 13, 2007 at 6:20 PM, reflected that client #2 had exhibited four incidents of his targeted behavior of physical aggression. The facility's policy on psychotropic medications was reviewed on July 13, 2007 at 3:35 PM. The policy reflected that "for individuals receiving medications for a prolonged period of time, it is often necessary to make a systematic and carefully monitored attempt to reduce and/or discontinue medications in order to know if they are necessary and appropriate." There was no evidence that an attempt to decrease the psychotropic medications had been considered or planned for client #2.	{W 316}	At the last psychotropic medication review of August 23 the psychiatrist was informed of the need to make an attempt at deceasing individual #4 psychotropic medication. The psychiatrist explained that his policy is only to make a reduction in a persons psychotropic medication after zero targeted behavior have been exhibited for eight consecutive months. See Attachment #20	9/26/07
{W 322}	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and	{W 322}		

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{W 322}	Continued From page 27 general medical care. This STANDARD is not met as evidenced by: Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of five clients included in the sample. (Client #2 and #3) The findings include: a. Interview with the Qualified Mental Retardation Professional (QMRP) and record verification on 8/27/07 at approximately 7:28 PM revealed no documented evidence that Client #2's prolactin levels had been completed since July 2007. b. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at at approximately 7:33 PM, it was acknowledged that Client #3 had not returned to back for his colonoscopy follow up visit in one year as recommended. The QMRP indicated that Client #2 last colonoscopy appointment was back in June 2006. ********** ********** Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of three clients in the primary sample. The finding includes: 1. During the medication administration that was	{W 322}		

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{W 322}	Continued From page 28 observed on July 12, 2007 at 7:10 PM, client #2 administered Clonazepam 0.5 mg and Risperdal 2 mg. The physician's orders (POS) were reviewed on July 12, 2007 at approximately 2:00 PM. The POS identified the need for fasting blood sugar levels, complete metabolic profile (CMP), prolactin levels every six months, and lipid profile every three months. At the time of the survey, there was no documented evidence that these studies had been conducted since July 2006. 2. According to the nursing assessment dated April 28, 2007, client #3 was seen for a colonoscopy in June 2006 and was required to return in one year. At the time of the survey, client #3 had not returned to have the testing conducted.	{W 322}	a. Individual #2's prolactin levels have been tested. See attachment #15 b. Individual #3's colonscopy has been scheduled. See attachment # 16	9.26.07 9.26.07
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that nursing services were provided in accordance with clients needs for two of five clients in the sample (Clients #2 and #3). The findings include: a. Interview with the Qualified Mental Retardation Professional (QMRP) and record verification on 8/27/07 at approximately 7:28 PM revealed no documented evidence that Client #2's prolactin levels had been completed since July 2006.	{W 331}		

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{W 331}	Continued From page 29 b. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at at approximately 7:33 PM, it was acknowledged that Client #3 had not returned to back for his colonoscopy follow up visit in one year as recommended. The QMRP indicated that Client #2 last colonoscopy appointment was back in June 2006. ********** Based on observation, interviews, and record review, the facility failed to ensure that nursing services were provided in accordance with clients needs for two of three clients in the sample (#2, #3). The findings include: 1. During the medication administration that was observed on July 12, 2007 at 7:10 PM, client #2 administered Clonazepam 0.5 mg and Risperdal 2 mg. The physician's orders (POS) were reviewed on July 12, 2007 at approximately 2:00 PM. The POS identified the need for fasting blood sugar levels, complete metabolic profile (CMP), prolactin levels every six months, and lipid profile every three months. At the time of the survey, there was no documented evidence that these studies had been conducted since July 2006. 2. According to the review of Client 3's medical records, conducted on July 12, 2007 at 2:26 PM, the client had a biopsy performed in May 2006. The record revealed that the client had polyps, however the results of the biopsy was not apart of the client's records.	{W 331}	1. a. Individual #2's prolactin levels have been tested. See attachment # 15 2. The result of the colonscopy are in the individuals chart. See attachment # 16	9.26.07 9.26.07

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{W 331}	Continued From page 30 3. According to the nursing assessment dated April 28, 2007, client #3 was seen for a colonoscopy in June 2006 and was required to return in one year. At the time of the survey, client #3 had not returned to have the testing conducted.	{W 331}	3. See W 331 #2	
{W 441}	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on the review of fire drill records the facility failed to ensure that clients in the facility had been trained and supported to evacuate the facility during general sleep hours. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at at approximately 7:33 PM, it was acknowledged the fire drill scheduled has not been revised and implemented by the home supervisor and checked regularly by the QA consultant as indicated in the Plan of Correction dated 8/20/07.	{W 441}	The fire drill schedule has been revised and will be implemented by the Home Supervisor and will be checked regularly by the QA Consultant. See Attachment #19.	9.26.07

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{I 000}	INITIAL COMMENTS This follow up licensure survey was conducted August 27 and 28, 2007. The resident sampling included three residents selected from the initial survey conducted on July 13, 2007 and two other residents who was not in the previous sample.	{I 000}		
{I 056}	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on interview and record review, the Program Director failed to have a facility staff person with food handlers certification. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:43 PM, it was acknowledged that no facility working the second shift (4:00 PM to 12:00 AM) had food handlers certification. Further interview with the QMRP revealed that a food handlers training class has been scheduled for 9/5/07. Review of the staff in service/orientation records on 8/28/07 at approximately 11:15 AM revealed no staff on schedule working the second had food handlers certification. There was no documented evidence that staff had received food handlers training at the time of the survey. **********	{I 056}	A Food Handlers Training for all Team leaders was held on September 12th, 2007. The facility's Office Manager will ensure that all staff keep their Food Handlers Training license current. See Attachment #19	9.26.07

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 9.27.07

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{I 056}	Continued From page 1 The finding includes: Staff files and trainings were reviewed on July 16, 2007 at 5:15 PM. The "Acting Qualified Mental Retardation Professional " stated that the facility was working on getting food service training for staff; however, at the time of the survey, there were no certified food handlers.	{I 056}		
{I 160}	3507.1 POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member. This Statute is not met as evidenced by: The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 5:58 PM, it was acknowledged that the facility have not contacted Clients #1, #2, #3, and #4's advocate, legal guardian, and/or family members to obtain consents forms or inform them about the use and side effects of psychotropic medications in which they were currently prescribed. Review of the Individual Support Plan (ISP) records on 8/27/07 at approximately 5:50 PM revealed no consents forms had been obtained for Clients 1 through 4. There was no documented evidence that the parents/guardians/advocates had been informed all medications and their side effects, and they have given consent for all treatments as indicated in the Plan of Correction dated 8/20/07. 5. The governing body failed to ensure that the clients #1, #2, and #3 received active treatment in	{I 160}	1. See W104 5. See W 196 & W 246	

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{I 160}	Continued From page 2 a consistent and persistent manner as described in W249 and W196. 6. The governing body failed to ensure that the policies were implemented to ensure the protection of clients rights. [See W264]	{I 160}		
{I 206}	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The findings includes: Review of the personnel records conducted on 8/28/07 at approximately 11:15 AM revealed that the following staffs are without current health certificates: [S3, S5, S9, S10, and S11]	{I 206}	2. The home supervisor will inform all staff that they are required to have an annual physical in order to work in the facility. All staff will have a current physical examination on file and any staff that are unable to produce one will be suspended without pay until they are able to produce one	9/26/07
{I 209}	3509.9(a) PERSONNEL POLICIES Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following: (a) Child or resident abuse or abuse of someone	{I 209}		

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{I 209}	Continued From page 3 under his or her care and supervision; This Statute is not met as evidenced by: The finding includes: Review of the personnel records conducted on 8/28/07 at approximately 11:40 AM revealed that the following staffs are without current police clearances for the state of Maryland: [S7-MD, S8-DC, S10-DC, S13-DC/MD]	{I 209}	The home supervisor will inform all staff that they are required to a obtain police clearance from the jurisdiction in which they have worked or resided in within seven years of their employment with the facility. All staff will have a police clearance on file and any staff that are unable to produce one will be suspended without pay until they are able to produce one.	9.24.07
{I 395}	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of five residents in the sample. (Resident #2 and #3) The findings include: 1a. Interview with the Qualified Mental Retardation Professional (QMRP) and record verification on 8/27/07 at approximately 7:28 PM revealed no documented evidence that Client	{I 395}	1. See W 331a	

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{I 395}	Continued From page 4 #2's prolactin levels had been completed since July 2007. b. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at at approximately 7:33 PM, it was acknowledged that Client #3 had not returned to back for his colonoscopy follow up visit in one year as recommended. The QMRP indicated that Client #2 last colonoscopy appointment was back in June 2006. 2. See Federal Deficiency Report Citations W331	{I 395}	1b. See W 331b 2. See W 331	
{I 401}	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record verification, the GHMRP failed to ensure professional services were provided timely for two of three residents in the survey. (Residents #2 and #3) The findings include: 1a. Interview with the Qualified Mental Retardation Professional (QMRP) and record verification on 8/27/07 at approximately 7:28 PM revealed no documented evidence that Resident #2's prolactin levels had been completed since July 2006.	{I 401}	a. See W 331a	

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{I 401}	Continued From page 5 b. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at at approximately 7:33 PM, it was acknowledged that Resident #3 had not returned to back for his colonoscopy follow up visit in one year as recommended. The QMRP indicated that Resident #2 last colonoscopy appointment was back in June 2006.	{I 401}	b. See W 331b	
{I 408}	3520.10(a) PROFESSION SERVICES: GENERAL PROVISIONS Professional services personnel shall offer consultation and instruction as appropriate to the following: (a) The resident ' s family; and... This Statute is not met as evidenced by: The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 6:18 PM acknowledged that the facility have not contacted Client #1, #2, #3, #4, and #5's parents/guardians/advocates to inform them about medications, consents, injuries or treatments. Further interview with the QMRP revealed that the letters to each individuals's circle of supports to inform them of individuals Individual Support Plans (ISP), quarterly meetings, and all psychotropic medications had not been written or mailed out. Record reviews conducted on 8/28/07 at approximately 12:23 PM revealed no letters had been written or mailed out in the correspondence section. There was no documented evidence that the Program Director and the Quality Assurance Consult ensured that these letters were written and sent out as indicated in the POC dated 8/20/07.	{I 408}	1. See W 148 & W 209	

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{I 408}	Continued From page 6 2. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:15 PM, it was acknowledged that the facility's HRC had not reviewed/discussed the person signing the medication/BSP consents is aware of the individual's condition, medication, side effects and rights. Review of the clients records on 8/27/07 and 8/28/07 revealed no documented evidenced that the facility's HRC had reviewed and discussed the person signing the medication/BSP consents is aware of the individual's condition, medication, side effects and rights as indicated in the POC dated 8/20/07. 3. Refer to federal deficiency report dated Citation W124	{I 408}	2. See W 264 3. See W 124	
{I 422}	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure Residents #2, and #3 were provided habilitation, training and assistance with their Individual Habilitation Plan (IHP). The findings include: 1. The facility failed to ensure continuous active treatment by not revising programs after clients failed to progress. [Refer to W257] 2. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:15 PM acknowledged that staff	{I 422}	1. W249 2. 196, & 189 #3	

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{I 422}	Continued From page 7 had not been using Resident #2's communication device in accordance with the Individual Support Plan (ISP) at the time of the survey. The QMRP indicated that she was unaware of how to use the communication device. The QMRP further indicated that she and the direct care staffs had not received training on the used of the communication device. Record verification on 8/27/07 at approximately 7:02 PM revealed an objective that read "will use his communications device to name two different items at any given time with total guidance. Further review of the staff in service/orientation record revealed no evidence that all facility staffs including the QMRP had been trained by the speech and language pathologists. There was no documented evidence that the objective was being implemented as recommended.	{I 422}		
{I 423}	3521.4 HABILITATION AND TRAINING Each GHMRP shall monitor and review each resident ' s Individual Habilitation Plan on an ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP. This Statute is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for five of five clients included in the sample. (Clients #1, #2, #3,#4, and #5) The findings include: The findings include:	{I 423}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G145	A. BUILDING _____ B. WING _____	R 08/28/2007

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{I 423}	Continued From page 8 1. The QMRP failed to ensure that clients received continuous active treatment services. [Refer to W196, W249] 2. The QMRP failed to ensure that clients' objective criterions, that had not been attained, had been considered for revision to increase the success for the clients.[Refer to W257]	{I 423}	1. W 196 & W 249 2. W 257	
{I 426}	3521.5(c) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (c) Is failing to progress toward identified objectives after reasonable efforts have been made; This Statute is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure that revisions were considered when clients' demonstrated a lack of achievement in attaining the established criterion levels for one out of five residents in the sample. (Resident #3) The findings include: 2. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:07 PM, it was acknowledged that Resident #3's objective to "write his home address with the help of a cue card with one verbal prompts twice a week for 3 consecutive months" had not been revised.	{I 426}	1. W246 #1	

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{I 500}	Continued From page 9	{I 500}		
{I 500}	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for four of five clients included in the sample. (Clients #1, #2, #3, and #4) The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 5:58 PM, it was acknowledged that the facility have not contacted Clients #1, #2, #3, and #4's advocate, legal guardian, and/or family members to obtain consents forms or inform them about the use and side effects of psychotropic medications in which they were currently prescribed. Review of the Individual Support Plan (ISP) records on 8/27/07 at approximately 5:50 PM revealed no consents forms had been obtained for Clients 1 through 4. There was no documented evidence that the parents/guardians/advocates had been informed all medications and their side effects, and they have given consent for all treatments according to the facility's POC dated 8/20/07. 2. Interview with the Qualified Mental Retardation	{I 500}	1. W249 & W 148 2. W249 & W 148	

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{I 500}	Continued From page 10 Professional (QMRP) on 8/27/07 at approximately 5:58 PM, it was acknowledged that the facility have not contacted Clients #1, #2, #3, and #4's advocate, legal guardian, and/or family members to obtain consents forms or inform them about the use and side effects of psychotropic medications in which they are currently prescribed. Review of the Individual Support Plan (ISP) records on 8/27/07 at approximately 5:50 PM revealed no consents forms had been obtained for Clients 1 through 4. There was no documented evidence that the parents/guardians/advocates had been informed all medications and their side effects, and they have given consent for all treatments according to the facility's POC dated 8/20/07. Additionally, there was no evidence that the facility's Registered Nurse (RN) made follow up phones calls to the advocate, legal guardian, and/or family members to ensure all their questions and concerns have been thoroughly answered as indicated in the Plan of Corrections dated 8/20/07.	{I 500}		